LOGO

Service-Level Agreement for the referral of patients to YOUR CENTRE for Dental Cone Beam CT Examinations

This agreement is between:

YOUR CENTRE Shenstone Dental Centre Tel: Fax: 01543 480 203 Email: enquiries@shenstone-dental.co.uk	The Clinician Name: Address: Tel: Email: GDC No:

Justification:

☐ I agree to use the referral criteria as per the European Guidelines: Radiation Protection No. 172 and provide adequate clinical information in order for each examination to be justified.

Reporting:

Please tick one of the following:

☐ I would like my Cone Beam CT to be reported by JM Radiology. The service will be provided by Dr J Makdissi, Consultant in Dental and Maxillofacial Radiology.

☐ I will make my own arrangement for the reporting of my Cone Beam CT scans acquired at YOUR CENTRE. This will be done by someone adequately trained as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT

☐ I will report my Cone Beam CT scans acquired at YOUR CENTRE. I confirm that I am adequately trained to interpret cone beam CT scans as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT. I will ensure that my training remains up to date.

These guidelines are available on
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340159/HPA-CRCE-010_for_website.pdf

If you need any help filling this agreement please do not hesitate to contact us.

For The Cone Beam CT Centre	For the clinician
Signature:	Signature:
Date:	Date: